Student Health Service
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University of St. Thomas
Part I—Health History

Name (Last, First, MI)			UST ID:
Home Address	City	State	Zip Code
Phone H: ( ) C: ( )	Birthdate (Mo/Day/Year)	Today's Date	

SYMPTOMS

Check (✓) symptoms you have experienced:

Have you experienced any of the following?

GENERAL
- ☐ Chills
- ☐ Depression
- ☐ Dizziness
- ☐ Emotional/Physical/Sexual abuse
- ☐ Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of weight
- ☐ Nervousness
- ☐ Sleep disturbance
- ☐ Suicidal thoughts
- ☐ Sweats
- ☐ Tattoos - Type and Location ______________________

EYE, EAR, NOSE, THROAT
- ☐ Bleeding gums
- ☐ Blurred vision
- ☐ Difficulty swallowing
- ☐ Double vision
- ☐ Earache
- ☐ Eye problems
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Ringing in ears
- ☐ Sinus problems

CARDIOVASCULAR
- ☐ Chest pain
- ☐ High blood pressure
- ☐ Irregular heart beat
- ☐ Low blood pressure
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Swelling of ankles
- ☐ Varicose veins

RESPIRATORY
- ☐ Cough
- ☐ Wheezing
- ☐ Shortness of breath

GASTROINTESTINAL
- ☐ Appetite poor
- ☐ Bloating
- ☐ Bowel changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive thirst
- ☐ Hemorrhoids
- ☐ Heartburn/Reflux
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Stomach pain
- ☐ Vomiting

GENITO-URINARY
- ☐ Blood in Urine
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Painful urination

MUSCLE/JOINT/BONE
Pain, weakness, numbness
- ☐ Arms
- ☐ Back
- ☐ Feet
- ☐ Hands
- ☐ Hips
- ☐ Legs
- ☐ Neck
- ☐ Shoulders

SKIN
- ☐ Bruise easily
- ☐ Hives
- ☐ Itching
- ☐ Change in moles
- ☐ Rash
- ☐ Scars
- ☐ Sore that won't heal

WOMEN only
- ☐ Abnormal Pap Smear
- ☐ Breast lump
- ☐ Extreme menstrual pain
- ☐ Hot flashes
- ☐ Nipple discharge
- ☐ Painful intercourse
- ☐ Vaginal discharge

Date of Last menstrual period _______________

Regular _____ Irreg. ______

Have you had a mammogram? _______________

Number of pregnancies: _________

Number of Children _______

MEN Only
- ☐ Lump in testicles
- ☐ Undescended testicle
- ☐ Penis discharge

SPORTS HISTORY: Have you ever…
- ☐ been restricted from sports or physical exercise?
- ☐ fainted during exercise?
- ☐ had chest pain or a racing heart during exercise?
- ☐ wheezed or coughed during exercise?
- ☐ had a family member die of sudden death before age 50?
- ☐ had signs or symptoms of marfans?

HABITS
Do you now or have you ever consumed:

Tobacco	☐ Y	☐ N ______
Alcohol	☐ Y	☐ N drinks/wk.____
Caffeine	☐ Y	☐ N Cups/day_____
Street Drugs	☐ Y	☐ N ______

CONDITIONS

Check (✓) conditions you have or have had in the past:

GENERAL
- ☐ ADD
- ☐ AIDS/HIV
- ☐ Alcoholism
- ☐ Anemia
- ☐ Anorexia
- ☐ Anxiety
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bipolar Disorder
- ☐ Bleeding Disorders
- ☐ Breast Lump
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical Dependency
- ☐ Chicken Pox
- ☐ Colitis (Crohn's Disease)
- ☐ Concussion
- ☐ Depression
- ☐ Diabetes
- ☐ Eating Disorder
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Eczema
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gonorrhea
- ☐ Gout
- ☐ Heart Disease/Murmur
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herpes
- ☐ High Cholesterol
- ☐ HIV Positive
- ☐ Liver Disease
- ☐ Malaria
- ☐ Measles
- ☐ Sexually Transmitted Disease
- ☐ Migraine Headaches
- ☐ Miscarriage
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Pacemaker/Defibrillator
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate Problem
- ☐ Psychiatric Care
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Seizures
- ☐ Stroke
- ☐ Suicide, Thoughts or Attempt
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Typhoid Fever
- ☐ Ulcers
- ☐ Vaginal Infections

RISK BEHAVIORS & HEALTH HABITS

Check (✓) if applicable:

DO/HAVE YOU …

☐ Yes	☐ No	Eat a balanced diet
☐ Yes	☐ No	Exercise regularly
☐ Yes	☐ No	Sleep 8 hours/night
☐ Yes	☐ No	Get dental care
☐ Yes	☐ No	Use seat belts
☐ Yes	☐ No	Do monthly breast exams/testicular exam
☐ Yes	☐ No	Ever had cholesterol level checked

HEALTH RISKS

☐ Yes	☐ No	Use STD prevention measures
☐ Yes	☐ No	Use stress reduction strategies
☐ Yes	☐ No	Attempted to stop or reduce smoking
☐ Yes	☐ No	Attempted to stop or reduce drinking alcohol
☐ Yes	☐ No	Drive after drinking alchohol
☐ Yes	☐ No	______________________________________
☐ Yes	☐ No	______________________________________

Continued →

Name (Last, First, MI)	Birthdate:	UST ID

MEDICATIONS

ALLERGIES: (Medications, foods, insects)

____

____

____

____

MEDICATIONS TAKEN REGULARLY: (Include: allergy shots, birth control, pain control, laxatives, vitamins, diet pills, antidepressants, inhalers, etc.)

Medication	Dosage	Frequency

FAMILY HISTORY

Fill in health information about your family:

Relation	Age	State of Health	Age at Death	Cause of Death	Check (✓) if your blood relatives had any of the following:	Disease	Relationship to you
Father						Alcohol/Chemical Dependency	
Mother						Asthma	
Brothers						Cancer	
						Depression	
						Diabetes	
						Heart Disease/Stroke	
Sisters						High Blood Pressure	
						High Cholestorol	
						Kidney Disease	
						Other:	

Father's occupation: ______________________ Mother's occupation: ______________________

Are you adopted: ☐ Yes ☐ No If your parents are divorced, how old were you at the time of the divorce? ______________

With whom do you live? ☐ Parents ☐ Mother ☐ Father ☐ Spouse ☐ Self ☐ Other ______________

HOSPITALIZATIONS

Year	Hospital	Reason for Hospitalization and Outcome

Serious Illness/Injury	Date	Treatment

MEDICAL PROVIDER

(Physician/Nurse Practitioner)

Name			Phone ( )
Address	City	State	Zip Code

NAME OF HEALTH INSURANCE

Primary Policy Holder Name:	**Policy #**

EMERGENCY INFORMATION

In case of emergency, please contact:

Name		Relationship	
Home Phone ( )	Work Phone ( )	Cell Phone ( )	
Home Address	City	State	Zip Code